		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005397

Facility Name: La Moine Christian Nursing Home

Address: 145 South Chamberlain - Box 770 (Number) Roseville (City) 61473-0770 (Zip Code)

County: Warren

Telephone Number: 309-462-2134 **Fax #** ( )

IDPA ID Number: 37-08415692003

Date of Initial License for Current Owners: 09/01/70

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2000 to June 30, 2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) William O Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,125	4,231		16,356	8
9	SNF/PED					9
10	ICF	6,953	4,888		11,841	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,078	9,119		28,197	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.03%

D. How many bed-hold days during this year were paid by Public Aid?
123 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	145,905	14,439	6,998	167,342		167,342		167,342			1
2	Food Purchase		140,784		140,784		140,784	(66)	140,718			2
3	Housekeeping	78,676	11,208		89,884		89,884		89,884			3
4	Laundry	41,220	12,409		53,629		53,629		53,629			4
5	Heat and Other Utilities			78,110	78,110		78,110	(4,307)	73,803			5
6	Maintenance	38,269	13,261	15,800	67,330		67,330	5,391	72,721			6
7	Other (specify):*											7
8	**TOTAL General Services**	304,070	192,101	100,908	597,079		597,079	1,018	598,097			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	994,435	46,719	7,533	1,048,687		1,048,687		1,048,687			10
10a	Therapy			4,256	4,256		4,256		4,256			10a
11	Activities	28,508			28,508		28,508		28,508			11
12	Social Services	54,108	1,896	2,567	58,571		58,571		58,571			12
13	Nurse Aide Training											13
14	Program Transportation			929	929		929		929			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,077,051	48,615	15,785	1,141,451		1,141,451		1,141,451			16
	C. General Administration											
17	Administrative	54,853		104,116	158,969		158,969	(78,315)	80,654			17
18	Directors Fees											18
19	Professional Services			11,758	11,758		11,758	8,031	19,789			19
20	Dues, Fees, Subscriptions & Promotions			15,005	15,005		15,005	(2,376)	12,629			20
21	Clerical & General Office Expenses	26,174	5,635	37,219	69,028		69,028	(2,702)	66,326			21
22	Employee Benefits & Payroll Taxes			290,184	290,184		290,184	2,339	292,523			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,043	4,043		4,043	2,252	6,295			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,544	17,544		17,544	946	18,490			26
27	Other (specify):*							3,596	3,596			27
28	**TOTAL General Administration**	81,027	5,635	479,869	566,531		566,531	(66,229)	500,302			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,462,148	246,351	596,562	2,305,061		2,305,061	(65,211)	2,239,850			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number La Moine Christian Nursing Home #0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			104,063	104,063		104,063	3,591	107,654			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			512	512		512		512			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			104,575	104,575		104,575	3,591	108,166			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	13,857	622		14,479		14,479		14,479			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,680	54,680		54,680		54,680			42
43	Other (specify):* **Other**			152	152		152		152			43
44	**TOTAL Special Cost Centers**	13,857	622	54,832	69,311		69,311		69,311			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,476,005	246,973	755,969	2,478,947		2,478,947	(61,620)	2,417,327			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(66)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,675)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,591	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(77)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,675)	21		24
25	Fund Raising, Advertising and Promotional	(2,770)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	1,212			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,460)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(37,736)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (37,736)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (59,196)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

La Moine Christian Nursing Home

ID# 0005397

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nursing Aide Training Rev	$ 25	21	1
2	Vending Machine	163	21	2
3	Activity Revenue	(1,400)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,212)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(66)	0	0	0	0	0	0	0	0	0	0	(66)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,675)	368	0	0	0	0	0	0	0	0	0	(4,307)	5
6	Maintenance	0	5,391	0	0	0	0	0	0	0	0	0	5,391	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,741)	5,759	0	0	0	0	0	0	0	0	0	1,018	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(78,315)	0	0	0	0	0	0	0	0	0	(78,315)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,031	0	0	0	0	0	0	0	0	0	8,031	19
20	Fees, Subscriptions & Promotions	(2,770)	394	0	0	0	0	0	0	0	0	0	(2,376)	20
21	Clerical & General Office Expenses	(19,964)	17,262	0	0	0	0	0	0	0	0	0	(2,702)	21
22	Employee Benefits & Payroll Taxes	0	2,339	0	0	0	0	0	0	0	0	0	2,339	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,252	0	0	0	0	0	0	0	0	0	2,252	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	946	0	0	0	0	0	0	0	0	0	946	26
27	Other (specify):*	0	3,596	0	0	0	0	0	0	0	0	0	3,596	27
28	**TOTAL General Administration**	(22,734)	(43,495)	0	0	0	0	0	0	0	0	0	(66,229)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,475)	(37,736)	0	0	0	0	0	0	0	0	0	(65,211)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number La Moine Christian Nursing Home **#** 0005397 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	3,591	0	0	0	0	0	0	0	0	0	0	3,591	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,591	0	0	0	0	0	0	0	0	0	0	3,591	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,884)	(37,736)	0	0	0	0	0	0	0	0	0	(61,620)	45

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Christian Homes, Inc	100.00%	$	$	1
2	V	5	Utilities				368	368	2
3	V	6	Maintenance				5,391	5,391	3
4	V	17	Administrative	100,416			22,101	(78,315)	4
5	V	18	Directors						5
6	V	19	Professional Services				8,031	8,031	6
7	V	20	Fees, Subscriptions				394	394	7
8	V	21	Clerical				17,262	17,262	8
9	V	22	Employee Benefits	4,770			7,109	2,339	9
10	V	23	Inservice Training						10
11	V	24	Travel&Seminar				2,252	2,252	11
12	V	26	Insurance				946	946	12
13	V	27	Depreciation				3,596	3,596	13
14	Total			$ 105,186			$ 67,450	$ * (37,736)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	This workpaper is not applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME La Moine Christian Nursing Home COUNTY Warren

FACILITY IDPH LICENSE NUMBER 0005397

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE (217) 732-9651 FAX #: (217) 732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	7-050-086-00	7-346 S31 T9 R2	$ 56.00	$
2.	7-050-069-00	7-329 S31 T9 R2	$ 94.46	$
3.	7-050-094-00	7-350 S31 T9 R2	$ 86.76	$
4.	7-050-092-00	7-349 S31 T9 R2	$ 137.86	$ 137.86
5.	7-050-087-00	7-347 S31 T9 R2	$ 56.00	$ 56.00
6.	7-050-089-10	S31 T9 R2	$ 328.10	$ 328.10
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 759.18	$ 521.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,150 B. General Construction Type: Exterior Steel Frame Masonry Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	1,360,680	1968	$ 10,992	1
2	Home Office			4,014	2
3	TOTALS	1,360,680		$ 15,006	3

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		1971	1971	$ 671,598	$ 16,565	40	$ 16,790	$ 225	$ 492,923	4
5	37		1975	1975	545,572	12,074	36	15,155	3,081	319,385	5
6			1971	1971	118,518		20				6
7			1975	1975	96,278		16				7
8	Home Office				28,643	936		936		12,435	8
	Improvement Type**										
9	Land Improvements			1974			20				9
10	Building Improvements			1977	2,335	52	33	71	19	1,209	10
11	Windows			1980	8,654	192	45	192	0	4,078	11
12	Windows			1980	8,415	191	44	191	0	3,916	12
13	Remodeling			1981	341	8	34	10	2	160	13
14	Remodeling			1981	2,643	60	34	78	18	1,204	14
15	Heating Systems			1982	50,515	2,526	20	2,526	(0)	47,573	15
16	Garage			1982	9,457	378	25	378	0	7,214	16
17	Water Meter			1982			20				17
18	Furnace			1983	5,889	294	20	294	0	5,292	18
19	Building Improvements			1983	5,309	123	33	161	38	2,255	19
20	Front Door Exchange			1984	1,142	27	35	33	6	466	20
21	Bagley House			1984			10				21
22	Land Improvements			1986			10				22
23	Office Remodel			1986	13,549	339	25	542	203	5,057	23
24	Ventilating Fan			1987	463		10			463	24
25	Storm Sewer			1987			20				25
26	Drainage Survey			1987			20				26
27	Lighting Fixture			1987			10				27
28	Land Improvements			1987			20				28
29	Angle Frame			1987			20				29
30	Storm Sewer			1987			20				30
31	Floor Tile			1988	2,089		5			2,089	31
32	New Kitchen A/C Pump			1988	1,556	104	15	104	(0)	1,352	32
33	Door Monitor			1989	1,170	78	15	78		975	33
34	Remodeling			1989	2,901	145	20	145	0	1,800	34
35	Construction in Progress			1989			20				35
36	Door Monitor			1989	2,218		10			2,218	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	E W SGL Door Monitor	1989	$ 1,057	$ 70	15	$ 70	$ 0	$ 834	37
38	Fire Alarm System	1990	16,365	818	20	818	0	9,339	38
39	Conventional Oven	1991	2,510	167	15	167	0	1,823	39
40	Light Fixtures	1991	395	2	10	2		395	40
41	Carpeting	1991	346		5			346	41
42	Trees & Schrubs	1991			20				42
43	Compressor	1992	1,126	113	10	113	(0)	1,102	43
44	Phone System	1992	623	62	10	62	0	594	44
45	Cubicle Track	1992	2,888	289	10	289	(0)	2,746	45
46	Hot Water System	1993	13,270	885	15	885	(0)	7,375	46
47	Remodeling	1993	5,233		5			5,233	47
48	Yard Barn	1994			7				48
49	Wallcoverings/carpet	1994	3,744		5			3,744	49
50	TV Antennae	1994	4,351	435	10	435	0	3,087	50
51	Flourscent Light Fixtures	1994	608		5			608	51
52	Wallcoverings	1995	1,445		5			1,445	52
53	Remodel 4 rooms	1995	2,862		5			2,862	53
54	Wallpaper	1995	600		5			600	54
55	Asphalt Parking Light	1995			10				55
56	Flourscent Light Fixtures	1995	908	91	10	91	(0)	531	56
57	Bus Barn-E Railroad	1995			20				57
58	Egress Locking System	1995	3,252	273	5	273		3,252	58
59	Floorcoverings	1995	3,856	386	5	386		3,856	59
60	Wallpaper	1995	3,821	383	5	383		3,821	60
61	Roof	1996	168,868	11,258	15	11,258	(0)	56,290	61
62	Roof Exhaustor	1996	750	150	5	150		737	62
63	3 foot Bathroom fixtures	1996	935	187	5	187		919	63
64	Wallcoverings	1996	874	175	5	175	(0)	846	64
65	Vinyl-S Wing Wallway	1996	3,012	602	5	602	0	2,860	65
66	Wallcoverings - 5 rooms	1996	2,946	589	5	589	0	2,700	66
67	Sewer/Garbage Disposal	1996	3,058	612	5	612	(0)	2,805	67
68	Ceiling Tile Laundry	1997	1,237	124	10	124	(0)	486	68
69	Water Softner System	1997	10,033	2,007	5	2,007	(0)	7,693	69
70	TOTAL (lines 4 thru 69)		$ 1,840,228	$ 53,770		$ 57,361	$ 3,591	$ 1,040,993	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,840,228	$ 53,770		$ 57,361	$ 3,591	$ 1,040,993	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,840,228	$ 53,770		$ 57,361	$ 3,591	$ 1,040,993	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,840,228	$ 53,770		$ 57,361	$ 3,591	$ 1,040,993	1
2	Energy Management System	1997	14,830	1,483	10	1,483		5,438	2
3	Replumb end of N H	1997	14,103	1,410	10	1,410	0	5,052	3
4	Wallcoverings	1997	985	197	5	197		706	4
5	Dining Room Windows	1997	6,533	653	10	653	0	2,340	5
6	Remodel Bathroom	1997	2,229	446	5	446	(0)	1,598	6
7	Remodel Office	1998	1,696	339	5	339	0	1,187	7
8	Wallpaper Restroom	1998	3,003	601	5	601	(0)	2,003	8
9	Overhead Door	1998			10				9
10	Carpet-Lobby	1999	2,566	513	5	513	0	1,411	10
11	Wallpaper-Hallways	1999	14,431	2,886	5	2,886	0	7,455	11
12	Motherboards-Fire Alarm	1999	1,385	277	5	277		693	12
13	Wallpaper-Restrooms	1999	5,733	1,147	5	1,147	(0)	2,294	13
14	Door Locking System	1999	9,490	1,898	5	1,898		4,112	14
15	Windows-Dining Room	1999	7,640	509	15	509	0	1,145	15
16	Landscaping	2000			10				16
17	Parking Lot Resurface	2000			3				17
18	Sign for Front of Building	2000			10				18
19	Serving Lamps	2000	1,470	294	5	294		564	19
20	Entrance Canopy w/Sidewalk	2000	3,577	358	10	358	(0)	686	20
21	Wallpaper	2000	1,164	233	5	233	(0)	369	21
22	Wallpaper	2000	5,430	1,086	5	1,086		1,358	22
23	Light Fixtures	2000	1,039	104	10	104	(0)	113	23
24	Seagull Fixture	2000	5,631	563	10	563	0	610	24
25	Deluxe Composite Stool	2000	1,404	140	10	140	0	152	25
26	Sink (North Port-R Med)	2000	908	91	10	91	(0)	167	26
27	Seagull Fixture (8)	2000	856	86	10	86	(0)	93	27
28	FLOOR BASE	2000	614	123	5	123	(0)	123	28
29	TOP TREATMENT (2)	2000	620	124	5	124		124	29
30	ZONELINE HEAT/ COOL	2000	7,218	481	15	481	0	481	30
31	DOUBLE SWING (51)	2000	1,595	319	5	319		319	31
32	ZONELINE HEAT/ COOL (11)	2000	7,476	415	15	415	0	415	32
33	MATTRESS (6)	2000	775	81	8	81	(0)	81	33
34	TOTAL (lines 1 thru 33)		$ 1,964,629	$ 70,627		$ 74,218	$ 3,591	$ 1,082,082	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,964,629	$ 70,627		$ 74,218	$ 3,591	$ 1,082,082	1
2	INSTALLATION OF ALK IN FREEZER	2000	9,498	871	10	871	(0)	871	2
3	FURNACE HEAT EXCHANGER	2000	1,448	169	5	169	(0)	169	3
4	WALLPAPERING SOUTH WING	2001	2,447	245	5	245	(0)	245	4
5	ENLARGE/REMODEL P.T. ROOM	2001	5,826	292	10	291	(1)	292	5
6	CABINETS	2001	574	13	15	13	(0)	13	6
7	WALK-IN COOLER (DOWN PAYMENT)	2001	5,000	125	10	125		125	7
8									8
9									9
10									10
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,989,422	$ 72,342		$ 75,931	$ 3,589	$ 1,083,797	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 186,390	$ 22,330	$ 22,330	$	Various	$ 253,062	71
72	Current Year Purchases	15,977	1,773	1,773		Various	1,773	72
73	Fully Depreciated Assets	146,973						73
74	HO Allocation	25,001	2,581	2,581			20,328	74
75	TOTALS	$ 374,341	$ 26,684	$ 26,684	$		$ 275,163	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	79 GMC Van	1979	$ 10,311	$	$	$	5	$ 10,311	76
77	Patient Transportation	1994 Ford Bus	1994	44,700	5,588	5,588		8	39,582	77
78										78
79	HO Allocation			5,444	1,164	1,164			1,678	79
80	TOTALS			$ 60,455	$ 6,752	$ 6,752	$		$ 51,571	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,439,224	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,778	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,654	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,591	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,410,531	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 109,095	$	$	86
87	Land Improvements	59,271	4,334	36,671	87
88	Other Building	16,717	767	6,046	88
89					89
90					90
91	TOTALS	$ 185,083	$ 5,101	$ 42,717	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Not Applicable	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 106,820	$	1
2	Cash-Patient Deposits	8,018		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	110,817		3
4	Supply Inventory (priced at)	19,964		4
5	Short-Term Investments	707,304		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	4,493		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 957,416	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	109,094		13
14	Buildings, at Historical Cost	1,975,353		14
15	Leasehold Improvements, at Historical Cost	59,269		15
16	Equipment, at Historical Cost	406,494		16
17	Accumulated Depreciation (book methods)	(1,418,120)		17
18	Deferred Charges	13,706		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	514,521		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,660,317	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,617,733	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 16,715	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,018		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,259		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	647		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 109,639	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 109,639	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,508,094	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,617,733	$	48

***(See instructions.)**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,604,333	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,604,333	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(96,239)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (96,239)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,508,094	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,648,182	1
2	Discounts and Allowances for all Levels	(474,660)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,173,522	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	975	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(1,212)	12
13	Barber and Beauty Care	18,103	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 17,866	23
	D. Non-Operating Revenue		
24	Contributions	82,471	24
25	Interest and Other Investment Income***	83,952	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 166,423	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	(128)	28
28a	Gains/Losses, Unrealized Gains/Losses	25,025	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,897	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,382,708	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	597,079	31
32	Health Care	1,141,451	32
33	General Administration	566,531	33
	B. Capital Expense		
34	Ownership	104,575	34
	C. Ancillary Expense		
35	Special Cost Centers	14,631	35
36	Provider Participation Fee	54,680	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,478,947	40
41	**Income before Income Taxes (line 30 minus line 40)****	(96,239)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (96,239)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,230	2,230	$ 48,738	$ 21.86	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	8,546	8,929	154,600	17.31	3
4	Licensed Practical Nurses	14,900	16,085	207,693	12.91	4
5	Nurse Aides & Orderlies	52,915	55,824	523,230	9.37	5
6	Nurse Aide Trainees		0			6
7	Licensed Therapist		0			7
8	Rehab/Therapy Aides		0			8
9	Activity Director		0			9
10	Activity Assistants	2,765	2,966	28,508	9.61	10
11	Social Service Workers	4,958	5,319	54,108	10.17	11
12	Dietician		0			12
13	Food Service Supervisor		0			13
14	Head Cook		0			14
15	Cook Helpers/Assistants	17,638	18,697	145,905	7.80	15
16	Dishwashers		0			16
17	Maintenance Workers	3,477	3,646	38,269	10.50	17
18	Housekeepers	8,271	8,840	78,676	8.90	18
19	Laundry	5,288	5,437	41,220	7.58	19
20	Administrator	1,792	1,904	54,853	28.81	20
21	Assistant Administrator		0			21
22	Other Administrative	835	887	6,696	7.55	22
23	Office Manager	1,738	1,847	19,478	10.55	23
24	Clerical	2,384	2,384	19,767	8.29	24
25	Vocational Instruction		0			25
26	Academic Instruction		0			26
27	Medical Director		0			27
28	Qualified MR Prof. (QMRP)		0			28
29	Resident Services Coordinator		0			29
30	Habilitation Aides (DD Homes)	3,623	3,623	40,407	11.15	30
31	Medical Records		0			31
32	Other Health Care(specify)		0			32
33	Other(specify) Beauty Shop	1,193	1,291	13,857	10.73	33
34	TOTAL (lines 1 - 33)	132,553	139,909	$ 1,476,005 *	$ 10.55	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	142	$ 6,998	1.3	35
36	Medical Director		500	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	0	4,158	10.3	39
40	Physical Therapy Consultant	0	3,033	10a.3	40
41	Occupational Therapy Consultant	0	312	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	0	910	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	39	2,567	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	181	$ 18,478		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wirt Thompson	Administrator	0	$ 54,853
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,853

B. Administrative - Other

Description	Amount
Management Fee	$ 100,416
Other Admin Expense	3,700
TOTAL (agree to Schedule V, line 17, col. 3)	$ 104,116
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Lewis Jockey & Brown	Legal	$ 866
Hattery Simpson West	Legal	3
Booth & Antoline	Legal	221
Van Ostrand	Legal	4,159
Other		6,510
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,758

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,304
Unemployment Compensation Insurance	3,000
FICA Taxes	114,337
Employee Health Insurance	52,600
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	6,785
Employee Physicals	984
Employee Bonus	70,974
Workers Comp Med Exp	200
HO Allocation	2,339
TOTAL (agree to Schedule V, line 22, col.8)	$ 292,523

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,550
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Fees	7,685
HO Allocation	394
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,629

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached Detail	4,043
HO Allocation	2,252
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,295

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 2000 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **INHAA/IAHA $6449.25**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **305** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,680**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(66)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will be provided upon completion**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.